# The Columbia Protocol: Reducing Suicide, Reducing Liability, and Redirecting Scarce Resources Across States, Healthcare & Beyond

## A Policy Tool and Vital Part of Health and Wellness for Employees, Their Families and Communities

***Just Ask. You Can Save a Life.***

**Kelly Posner Gerstenhaber, Ph.D.**

Professor, *Columbia Psychiatry*
Recipient, *Secretary of Defense Medal for Exceptional Public Service*
Founder and Director, *The Columbia Lighthouse Project*

# Suicide is a Problem of Humanity, But It is Preventable! It is the Tragic Paradox That Takes…

**More Fire Fighters than Fire**

**More Police Officers than Crime**

**More Soldiers than Combat**

**More Teenage Girls than All Other Causes**

**More People than Car Accidents**

**…More Lives than Natural Disasters, War and Homicide**

**But the Great News:**

Suicide rate decreased 2% in 2019 for the first time in 2 decades, and fell another 6% in 2020 amid the pandemic

***ss Generations***

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# Increasing Global Crisis in Children, Particularly Minorities

## #1 Killer of Adolescent Girls Across the Globe

## 3rd Leading Cause of Death Among U.S. 10-24 Year-olds






**Suicide among 8-14 year olds was up 150% in recent 7 years**

**Increase in suicide in 5-year-old African American preschoolers**

**Between 1999 and 2018, the suicide rate for Black youth age 10-17 rose 87%**

**Suicide is the leading cause of death for Asian American/Pacific Islanders age 15-24**

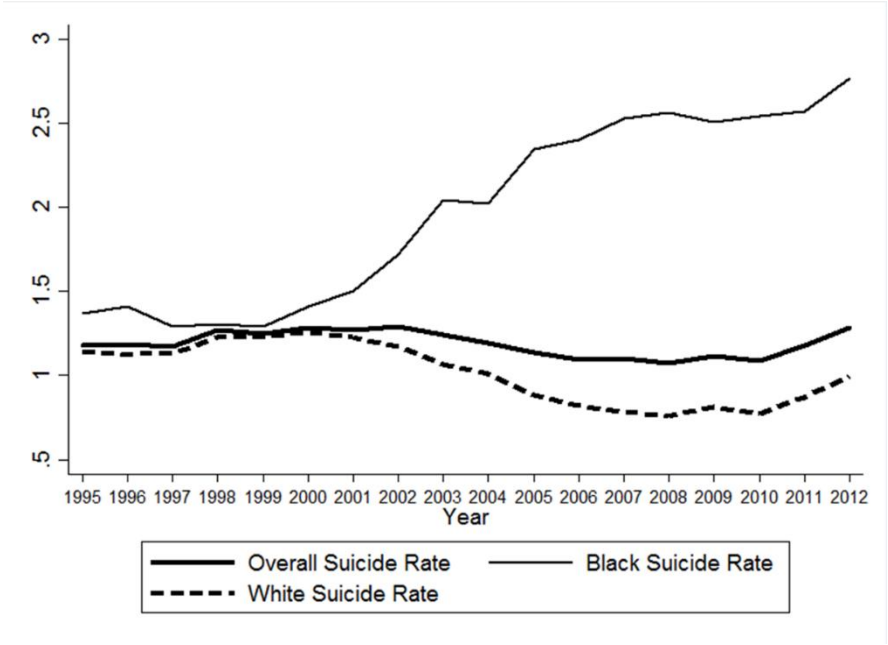
# Intersection of Humanitarian Crises – The Racial Disparity and Unrest in The U.S.

*Racial Inequality Reflected in Worsening Suicide Rates for African Americans*

## Significant Upward Trend Among African American Youth

**Figure 1.** Trends in suicide rate among black and white children in the United States, ages 5 to 11, compared to overall trend from 1993 to 2014.

*Logan, Yershova, Mandzyiev (JAACAP, 2016)*




Overall stable suicide trends continue to mask significant upward trends among minority children **age 5-11**

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# The Magnitude… U.S. Life Expectancy Decreased: Suicide Deaths Play a Role

Health & Science

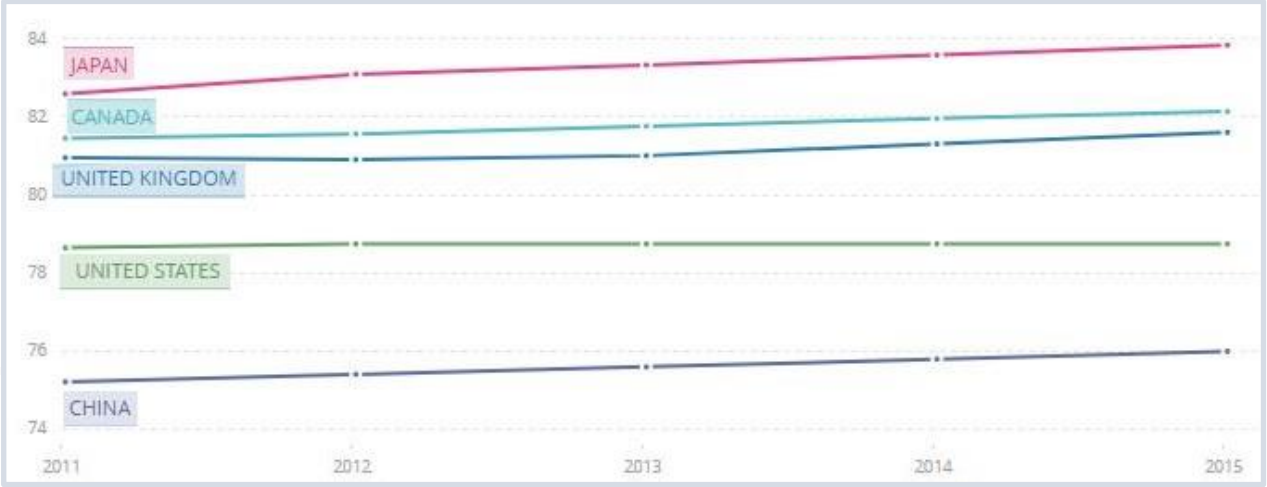
## U.S. life expectancy declines for the first time since 1993

By Lenny Bernstein December 8, 2016


The Post's Lenny Bernstein explains a report that shows life expectancy for Americans has declined in 2015 for the first time since 1993. (Monica Akhtar, Gillian Brockell/The Washington Post)

For the first time in more than two decades, life expectancy for Americans declined last year — a troubling development linked to a panoply of worsening health problems in the United States.

Anomaly Among Developed Nations

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# Touches Everyone… Vital Part of Health & Wellness for Employees & Their Families

*Need to Screen Everywhere and Care for the Caregivers*

**#1 cause of death for nurses and male medical residents**


In a company of 100,000 employees:

- **Every 6 days,** one employee or family member will die by suicide
- **Every day, 3 attempts**

DHS is committed to the well-being of all of their employees – providing mental health resources alongside nutrition and physical fitness.






**Firefighters utilize the C-SSRS in 3 ways:**

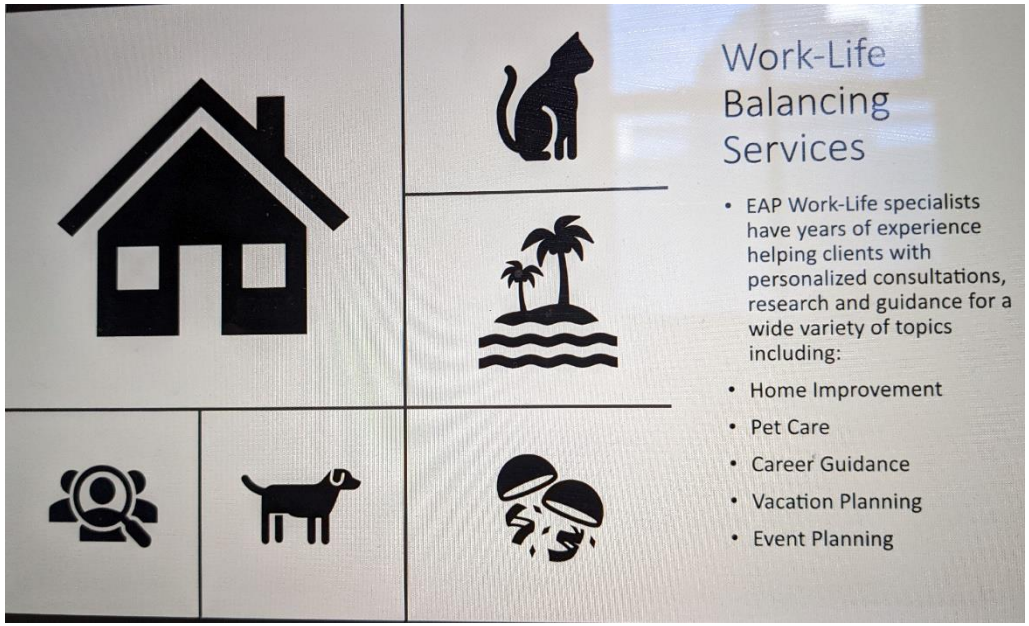
**1)** To screen civilians in the community who are potentially suicidal to determine what treatment is appropriate.

**2)** To identify members in the Department who are in need of assistance.

**3)** To recognize family members of firefighters who may be at risk of suicide.

# Taking Care of Families: Woven into EAPs Alongside Other Services and Resources

- Counseling benefits (family issues, substance use, stress management)
- Legal assistance (family law and retirement planning)
- Childcare and elder care support
- Work-Life balancing services

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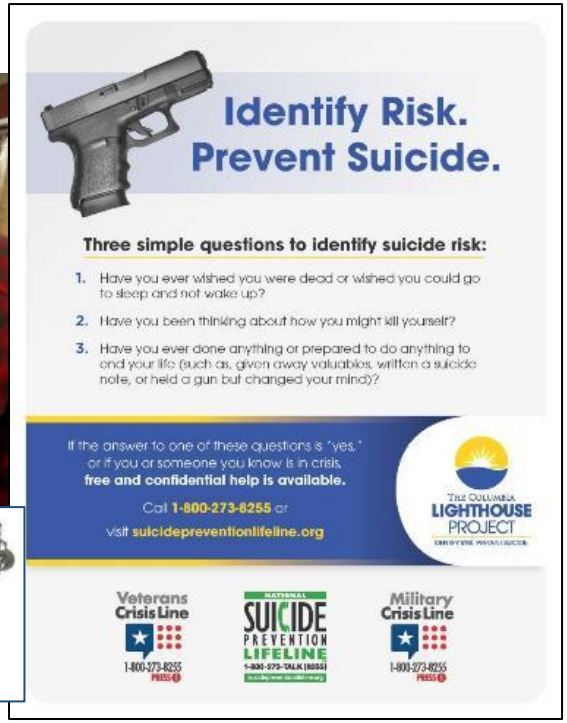
# The Gun Death Crisis and the Need to Go Beyond the Hospital: 2/3 of Gun Deaths are Suicides

**3 Thousand Mass Shootings in the US Since Sandy Hook**

**90% of school shooters have a history of suicidal issues**

***The Gun Buyer Wants to be Saved***




"The Highest Form of 'See Something Say Something'"

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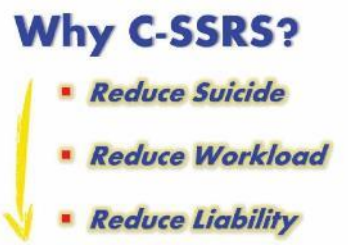
# The High Cost of NOT Screening:
## What Not Identifying High Risk Costs Society

- US (2010): **$91 billion in lost wages and work productivity**
- **Worldwide: $300 billion in** years of life disabled or lost
- 1,000 Non-Psychiatric Screened at Colorado University

  Prior: *400% increase in hospitalizations*

  Over past 2 years: *300% increase in ED visits*




## Look What Happens When You Do:

CENTERSTONE **the largest provider of outpatient community behavioral healthcare in the U.S., reduced their suicide rate 65% over 20 months, and reduced ED recidivism from 40% to 7%.**

Atrium Health **acute care facilities saw a 50% reduction in suicide after implementing C-SSRS in April 2019.**

**Atrium Health Behavioral Health Service Line saw an 86% reduction!**

# The Power of Asking Beyond the Doctor's Office: Look at the Effect This Has Already Had in Largest Community BH System in US

## Reduced their suicide rate 65% over 20 months



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# Beyond the Doctor's Office: First Responders Asking Routinely and Right Away Increases Appropriate Identification of Who's at Risk and Increased Voluntary Admissions

## Mobile Crisis: part of the Magellan Behavioral Health in PA

- Crisis services meet individuals WHERE THEY ARE
- When dispatched to a community location, the team **provides clinical interventions to help the individual and their natural supports** (i.e., family, friends, neighbors, faith communities, etc.) stabilize the crisis situation, assess the individual for the level of care needed to provide ongoing crisis support, and facilitate the referral process to ensure individuals get the help they need.
- increased scores associated with greater likelihood of BOTH voluntary and involuntary hospitalization
- Compared to staying home with supports:
  - a person is 66% more likely to be recommended for voluntary hospitalization for C-SSRS score increase
  - **but** only 42% more likely to be recommended for involuntary hospitalization for every increase

**PA mobile mental health program focused on screening and meeting individual needs at the local level. The CSSRS scores increased the likelihood of voluntary rather than involuntary care recommendations.**

# Vital Part of Saving Lives: Need to Ask Like Blood Pressure to Find People Suffering in Silence

Over 50% of people who die by suicide saw their primary care doctor the month before they die

2/3 of adolescent attempters in ER are not typically present for psychiatric reasons

**Screen more at times of higher risk, e.g. transition from active duty to veteran status, relocation, anxiety about in-person school/work**

## VITAL OPPORTUNITIES FOR PREVENTION:

**Imagine every school nurse, physical therapist or EAP asking about mental health alongside physical checkups. *If we ask, we can find those suffering in silence.***

**Universal screening in an Ohio school system:** Hundreds of students screened electronically – just 5% requiring a next step. Reports were sent to school admin so counselors could follow-up right away with appropriate care.

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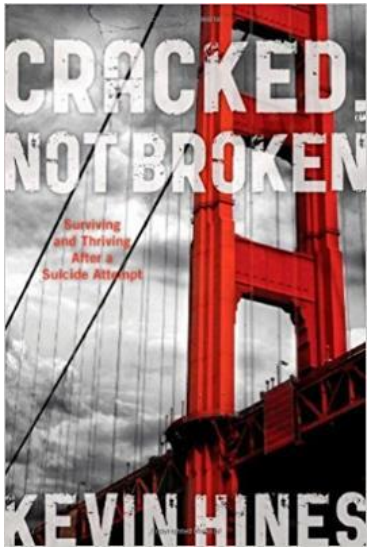
# People Want to Be Saved & Need to be Asked Everywhere They Acquire Means




**"Most people considering suicide *want someone to save them*. What we need is a culture in which no one is afraid to ask.** What we needed were the questions people could use to help save us. That's why the pioneering change the C-SSRS is enabling is so essential to our humanity." - *Kevin Hines, Survivor*

- **Transit Workers**
- **Pharmacies**
- **Gun shops**
- **Pesticide Suppliers**

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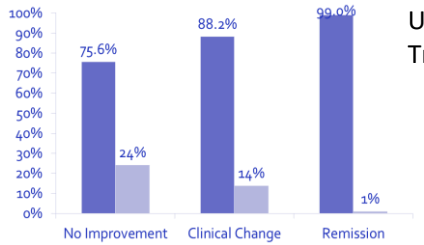
# Normalizing Screening and Reducing Stigma Saves Lives in the US Army

**Millions of Screens**




U.S. Army PTSD Treatment Outcome

***Data leads to additional funding***

Military, highest risk post-hospitalization – struggle to reintegrate into unit, stigma, false sense of recovery so this prevents post-hospitalization risk sequelae

**Elevated risk for 2 years after discharge**

- Treatment is no longer at a stigmatizing outpost
- Mental health questions (including C-SSRS) were integrated into care
- **Inpatient overnights reduced 41%, saving $30-40 million since 2012**
- Decrease in suicide

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# The Power of Asking to Help Reduce Gun Deaths and Their Traumatic Aftermath:

## Former Deputy Secretary of Education Said The Columbia Can Help Keep our 64 Million Children Safe


After the Navy Yard shooting…

**"What is it going to take to make this ubiquitous?"**

"…**The Columbia has the potential to keep the 64 million children in our schools safe physically and mentally** by helping prevent school violence."

**- James Shelton, Former Deputy Secretary US Dept. of Education**

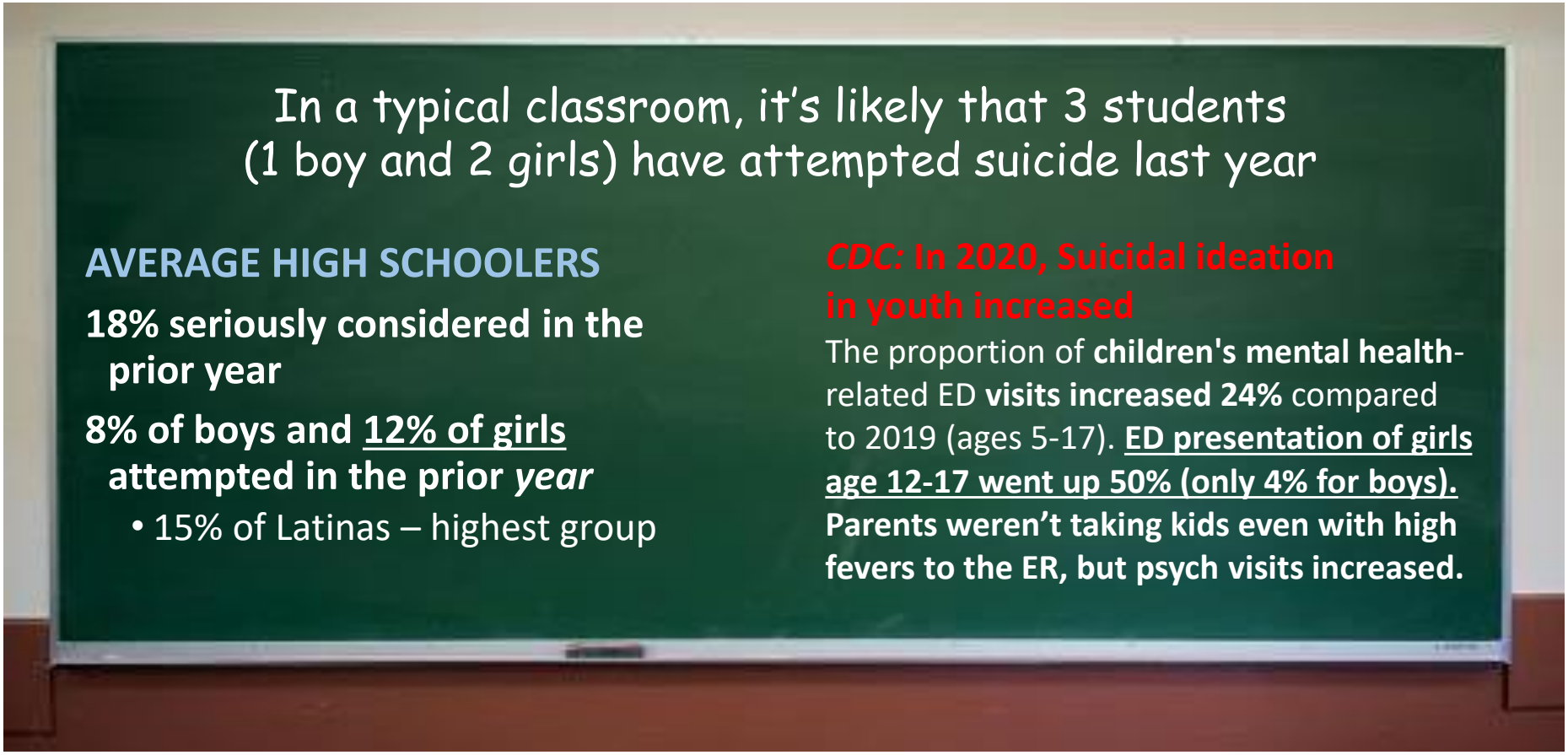
## Early Identification & Prevention Through Public Health Outreach

"I want every parent in our community to hold each other accountable. We should ask ourselves on social media and at the grocery store, have you asked the questions, right?" - Ryan Petty on CNN

Dr. Kelly Posner, Ryan Petty, and Senator Marco Rubio at the U.S. Senate forum on school safety, April 2018.

# Why Asking Our Kids Routinely is Critical

## Whether You're a Parent, Coach, Teacher or Peer

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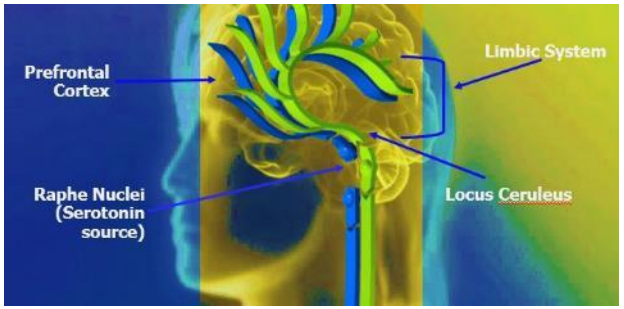
**Suicide attempts by Black adolescents rose 73% (compared to 18% rise among white adolescents)**

# Suicide is (mark all that apply):

a) A Choice
b) A Sign of Psychological Weakness
c) Akin to Murder (Only of the Self)
d) Akin to Cancer
e) All of the Above

**Biggest Cause:**
a heritable, treatable medical illness called Depression




***Suicide Is Not a Choice***

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# This Misunderstanding Can Be Lethal: Netflix Drama *13 Reasons Why* Sent Opposite Message


## Suicide Contagion:

The exposure to suicide or suicidal behaviors through **media,** within one's family, or peer group increases suicidal behaviors.

*Especially in adolescents and young adults*

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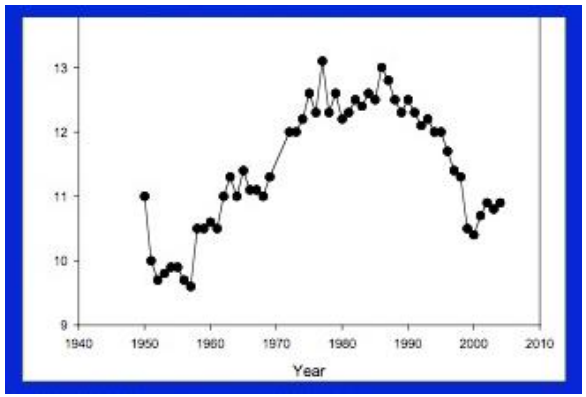
# Antidepressants Save Lives!

## Not Treating Depression is What Kills People

- Autopsy studies associated with *no treatment or non-compliance*
- *CDC: 76% no medication*





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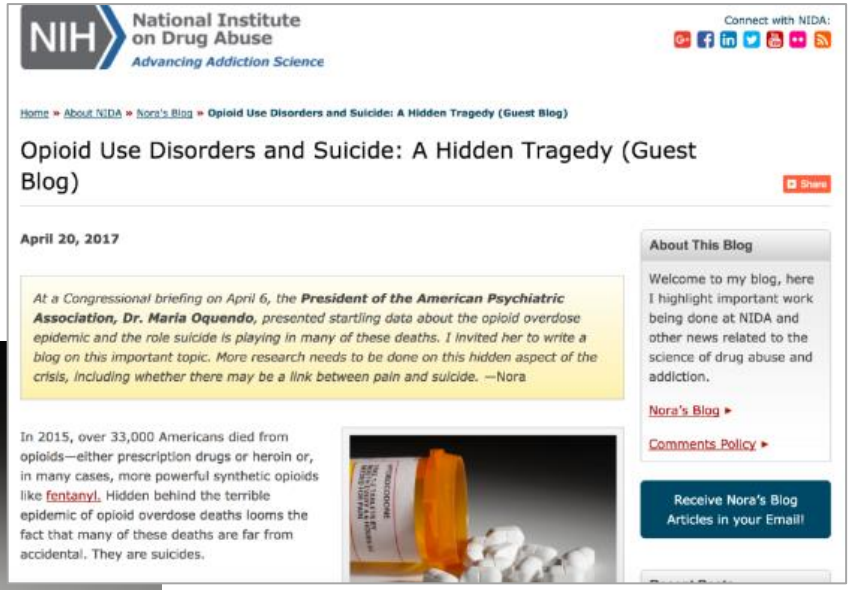
# Desperately Self-Medicating in Lieu of Proper Treatment:

## Large Portion of Overdoses Are Suicides



NIH National Institute on Drug Abuse
Advancing Addiction Science

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Opioid Use Disorders and Suicide: A Hidden Tragedy (Guest Blog)

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April 20, 2017

*At a Congressional briefing on April 6, the **President of the American Psychiatric Association, Dr. Maria Oquendo**, presented startling data about the opioid overdose epidemic and the role suicide is playing in many of these deaths. I invited her to write a blog on this important topic. More research needs to be done on this hidden aspect of the crisis, including whether there may be a link between pain and suicide. —Nora*

In 2015, over 33,000 Americans died from opioids—either prescription drugs or heroin or, in many cases, more powerful synthetic opioids like fentanyl. Hidden behind the terrible epidemic of opioid overdose deaths looms the fact that many of these deaths are far from accidental. They are suicides.

About This Blog

Welcome to my blog, here I highlight important work being done at NIDA and other news related to the science of drug abuse and addiction.

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**Opioids in 1 out of 5 suicide deaths**

Risk of opioid overdose among Veterans is <u>double the risk</u> for non-veterans

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# Unfortunately…
# Those Who Need Treatment Do Not Get It

**90% of people who die by suicide have an untreated mental health problem, most often of which is depression.**

**90% of youth suicides** were untreated at time of death.


## Under-treatment of mental illness is pervasive:

- 50-75% of those in need receive no or inadequate treatment
- Over 80% of adolescents and college students who die by suicide never received any consistent treatment prior to their death

**During COVID-19 crisis**, many people couldn't afford or access their prescriptions

Antidepressants are #1 Prescription in U.S.: "The fact that people are getting the treatments they need is encouraging. **We worry more about under-treatment than over-treatment."**

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# Why Don't People Get the Life-Saving Care They Need?

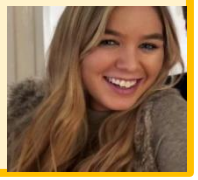
# Why Is Screening So Important for Everyone? Stigma and Misunderstanding Can be Lethal

## "This isn't a real illness; I'm weak if I ask for help"

**"…it's the stigma attached to admitting you have any kind of problems that gets in the way of beating depression. But when you see a real person up there… they know they're not alone and can go out and get help."**

"People talk about cancer freely; why is it so difficult to discuss the effects of depression? … **As students, we have the power to end that immediately.** Stigma places blame on the person suffering from the illness and makes them ashamed to talk openly about what they're going through."

***- Saoirse Kennedy-Hill, in an essay she wrote before her tragic suicide***



**Culture of Machismo from Baseball to Border Protection**

"That's the thing with athletes, like **you're not really supposed to show your weaknesses** kind of thing, 'cause that like lets your competitors know, so that's why a lot of the time you wouldn't go to the psychologist or whatever, just 'cause that becomes your weakness." - *MLB Player*

- **73% of doctors feel there is stigma in their own workplace**
- **3 in 5 emergency physicians worried mental health treatment would affect**
- **60-85% are concerned that formal treatment could affect their medical license**

***It's a Sign of Strength to Ask for Help***

# This Barrier Impacts Identification of Risk: Men and Boys Don't Seek Help So We have to Go Find Them

## Men and Boys… Seek Less Treatment?

### Suicide Attempts:

- Female > male
- Rates peak in adolescence
- Concern: Latina youth and LGBTQ

### Suicide Deaths:

- Male : female = 4:1
- **41% vs 11% antidepressants in system**
- Working-age males (60%)

**Mental health ED visits for girls age 12-17 went up 50% (only 4% for boys).**

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# Stigma Can Be Life Threatening

## Vital Role of Family, Spouses and Parents in Screening for Detection of High Risk:

### Find People Where They Work and Live

[My husband] said to his buddy, his fellow marine, "everybody goes through this." He was empathic; he said "you know, we've all been there. Take some time, take care of yourself. **But don't go to treatment and don't go on medication because *you cannot do that and fly."*** - Kim Ruocco


- **Until 2010, pilots were banned from flying if on antidepressants, causing many pilots to lie about or ignore signs of depression**
- **8 suicides in 15 months**

***Making Progress:* A majority of Americans now say mental health is as important as physical health**

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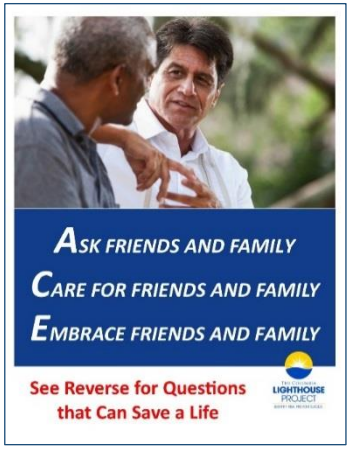
# The Columbia: A Few Simple Questions to Identify Who Needs Help and Connect Them to Care

Minimum of 2 Questions — Maximum of 6 Questions





| Always ask questions 1 and 2. | Past Month |
|---|---|
| 1) Have you wished you were dead or wished you could go to sleep and not wake up? | |
| 2) Have you actually had any thoughts about killing yourself? | |
| If **YES** to 2, ask questions 3, 4, 5 and 6.<br>If **NO** to 2, skip to question 6. | |
| 3) Have you been thinking about how you might do this? | |
| 4) Have you had these thoughts and had some intention of acting on them? | High Risk |
| 5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan? | High Risk |
| **Always Ask Question 6** | Life-time / Past 3 Months |
| 6) Have you done anything, started to do anything, or prepared to do anything to end your life?<br>*Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc. | High Risk |

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Any YES indicates that someone should seek behavioral healthcare.
However, if the answer to 4, 5 or 6 is YES, seek immediate help: go to the ER, call 1-800-273-8255, text 741741 or call 911. STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

## Primary Care Screener

COLUMBIA-SUICIDE SEVERITY RATING SCALE
*Screen with Triage Points for **Primary Care***

| Ask questions that are in bold and underlined. | Past month YES | NO |
|---|---|---|
| **Ask Questions 1 and 2** | | |
| 1) ***Have you wished you were dead or wished you could go to sleep and not wake up?*** | | |
| 2) ***Have you had any actual thoughts of killing yourself?*** | | |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.** | | |
| 3) ***Have you been thinking about how you might do this?***<br>e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it…and I would never go through with it.*" | | |
| 4) ***Have you had these thoughts and had some intention of acting on them?***<br>as opposed to "*I have the thoughts but I definitely will not do anything about them.*" | | |
| 5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** | | |
| 6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** | Lifetime | |
| Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. | Past 3 Months | |
| **If YES, ask:** ***Was this within the past 3 months?*** | | |

**Response Protocol to C-SSRS Screening**

Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Behavioral Health Consultation and Patient Safety Precautions
Item 5 Behavioral Health Consultation and Patient Safety Precautions
Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions

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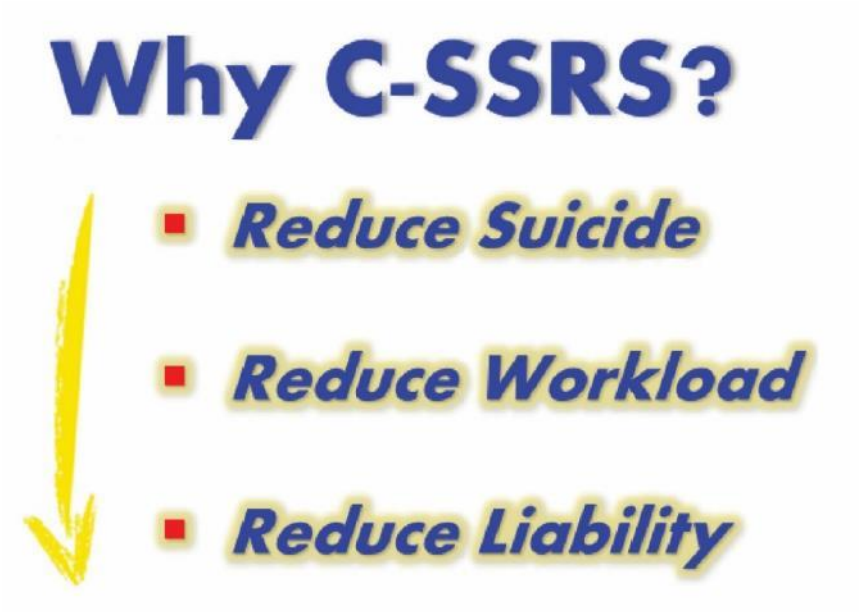
# *Just Ask, You Can Save a Life:*

## Columbia-Suicide Severity Rating Scale (C-SSRS)




- **Developed in a NIMH effort**
- **100s of millions of administrations**
- **Over 140 languages**
- **Endorsed, Recommended, Adopted or Mandated by National and International Agencies (CDC, FDA, DOD, NIMH)**

FDA PhenX consensus measures for Phenotypes and eXposures

NIMH National Institute of Mental Health

CDC Centers for Disease Control and Prevention

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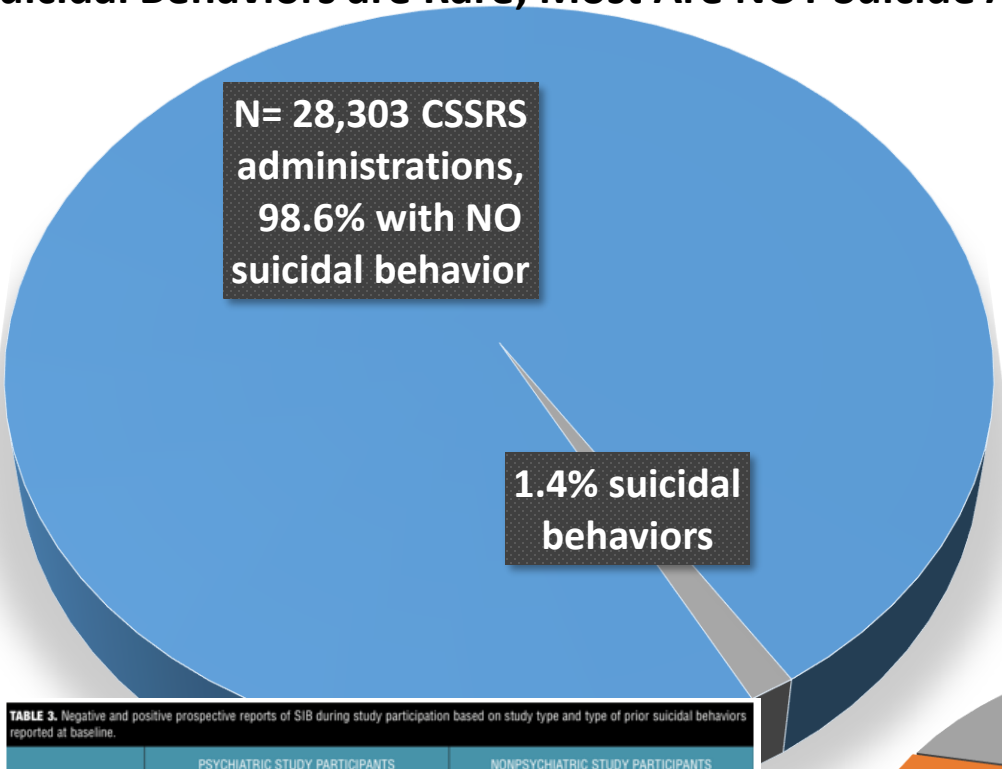
Identify Risk. Prevent Suicide.

# Why Are These Questions Different?

## Highlights from the Science:

### Suicidal Behaviors are Rare; Most Are NOT Suicide Attempts



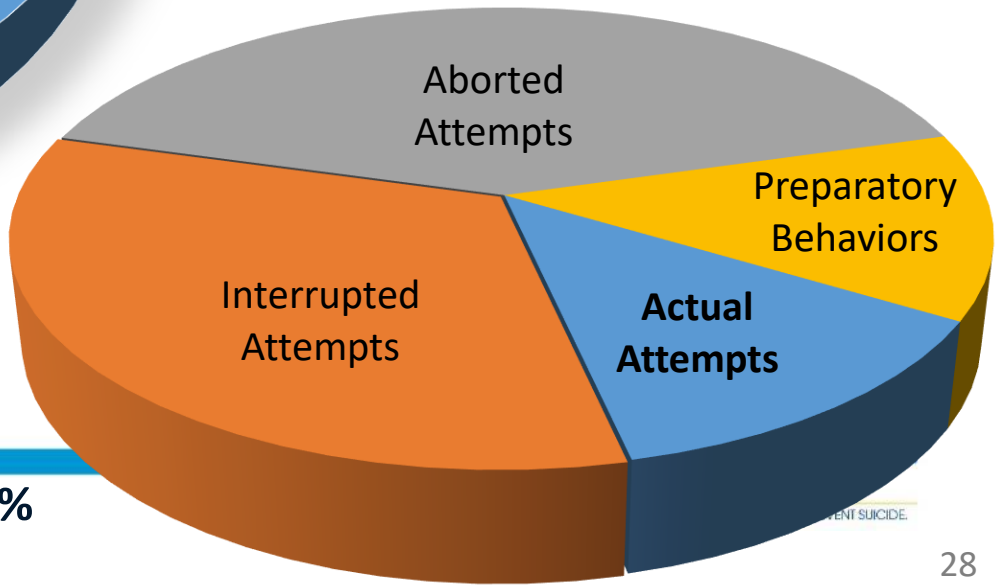

We used to only ask about a suicide attempt, and **missed the person who bought the gun, or wrote the suicide note, or put a noose around their neck and changed their mind.**

**Of the 1.4% suicidal behaviors:**
**87% (472) = interrupted + aborted + preparatory**
**vs.**
**13% (70) actual attempts**

**TABLE 3.** Negative and positive prospective reports of SIB during study participation based on study type and type of prior suicidal behaviors reported at baseline.

| BASELINE REPORTED LIFETIME SIB | PSYCHIATRIC STUDY PARTICIPANTS | | | NONPSYCHIATRIC STUDY PARTICIPANTS | | |
|---|---|---|---|---|---|---|
| | Prospective Behavior | | | Prospective Behavior | | |
| | Negative | Positive | OR (95% CI)* | Negative | Positive | OR (95% CI)* |
| No actual suicide attempts | 5,464 | 187 | -- | 2,027 | 10 | -- |
| Actual suicide attempt | 959 | 150 | 4.57 (3.6–5.7) ** | 39 | 1 | 5.20 (0.7–41.6) ns |
| No interrupted suicide attempt | 5,792 | 210 | --- | 2,031 | 8 | |
| Interrupted suicide attempt | 631 | 127 | 5.55 (4.4–7.0) ** | 35 | 3 | 21.76 (5.5–85.5) ** |
| No aborted suicide attempt | 5,576 | 190 | -- | 2,020 | 8 | -- |
| Aborted suicide attempt | 847 | 147 | 5.09 (4.1–6.4) ** | 46 | 3 | 16.47 (4.2–64.1)** |
| No preparatory behavior for an attempt | 6,105 | 260 | -- | 2,055 | 8 | -- |
| Preparatory behavior for an attempt | 318 | 77 | 5.69 (4.3–7.5) ** | 11 | 3 | 70.06 (16.4–299.6)** |

4X




100%

# Preparatory Behaviors

A **front desk staff member** noticed a patient in the waiting room who did not appear well. Because she had undergone training to know **it's okay to ask**, she had the knowledge and courage to ask the suicide question, which revealed high risk and **disclosure of a suicide note** which led to him being transported to the hospital.

By asking about all types of ideation and behaviors maybe we can find kids like Dylan Klebold (Columbine) who mentioned suicide more than 5x in his journals:

"I don't fit in here, thinking about suicide gives me hope."

Santa Fe shooter wrote in his journals that he wanted to kill people and then kill himself

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**Why C-SSRS?**

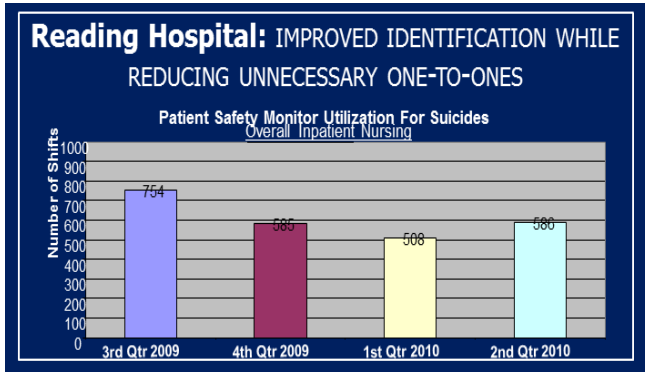
- *Reduce Suicide*
- *Reduce Workload*
- *Reduce Liability*

# Finally Knowing Who to Worry About:

## Screening with Evidence Supported Thresholds for Imminent Risk: Reduction of Workload, Reduction of False Positives

In Schools: No one knew who to worry about or who to refer

**Rhode Island:**
**Reduced Suicide and ED Holds**




*Suicide watch goes down and police* ***do not have to hospitalize***

**Indicates Need for Next Step**

COLUMBIA-SUICIDE SEVERITY RATING SCALE
*Emergency Department - Screen Version - Recent*

| SUICIDE IDEATION DEFINITIONS AND PROMPTS | Past month YES | NO |
|---|---|---|
| Ask questions that are bolded and underlined. | | |
| Ask Questions 1 and 2 | | |
| 1) Wish to be Dead: *Have you wished you were dead or wished you could go to sleep and not wake up?* | | |
| 2) Suicidal Thoughts: *Have you actually had any thoughts of killing yourself?* | | |
| If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6. | | |
| 3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it.*" *Have you been thinking about how you might do this?* | | |
| 4) Suicidal Intent (without Specific Plan): As opposed to "*I have the thoughts but I definitely will not do anything about them.*" *Have you had these thoughts and had some intention of acting on them?* | | |
| 5) Suicide Intent with Specific Plan: *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?* | | |
| 6) Suicide Behavior Question: *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If YES, ask: *Was this within the past three months?* | Lifetime / Past 3 Months | |

Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

**Only approx 1%** require a next step **Implications:** Determining if able to return "fit for duty."

***Dramatically reducing unnecessary interventions***

# *NEXT STEPS*

**Recent study from Sweden –** C-SSRS Screen Version: initial screening for suicide risk in a psychiatric emergency department – Predicted death by suicide (Bjureberg 2021)

# Questions Used to Facilitate Appropriate Care: Police Demo

Visit Youtube for demonstration video:

http://youtu.be/fx3N3uDUQbo

**Police Asking**
is Critical to Optimizing
Your Scarce Resources,
Decreasing ↓
Unnecessary ED Holds

THE COLUMBIA LIGHTHOUSE PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

# The Challenge to Caring for Students:
## No One Knew Who to Worry about or Who to Refer

- Four hospitals in NYC: **61-97% of student referrals did *not* require hospitalization**
- NYC DOE:
  - "The great majority of children & teens referred by schools for psych ER evaluation are not hospitalized & **do not require the level of containment, cost & care** entailed in ER evaluation."
  - "Evaluation in hospital-based psych ERs is **costly, traumatic** to children & families, and **may be less effective** in routing children & families into ongoing care."

***One student sat 9 hours in the principal's office waiting for an EMT!***

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# The ROI of Routine Screening: Primary Care and Beyond

## Using C-SSRS as Part of Zero Suicide Implementation

Avera Medical Group

**52% reduction in emergency psychiatric assessments**
**32% reduction in rehospitalization**

the Chickasaw Nation

**200 diversions from inpatient treatment, saving $200,000/year**

betty hardwick center

**Deaths reduced to zero**
**8% decrease in hospital admissions in 1 year, saving $23,400**

The Mental Health Center of Greater Manchester

**Decreased suicide 44%**

**C-SSRS-PHQ9: Reduce False Positives and Workload While Finding the Right People**

Air Force Zero Suicide: Increased sensitivity with C-SSRS across mental health clinics

at risk (intake) **16% PHQ9 vs 6.5% C-SSRS**

at risk (follow-up) **13% PHQ9 vs 1.3% C-SSRS**

Missouri Department of Mental Health

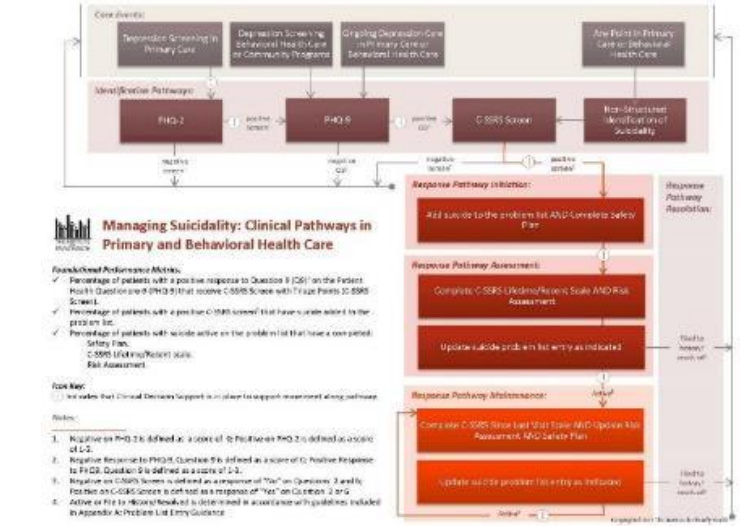
**32% decrease in suicide deaths over 2 years in community BH centers**

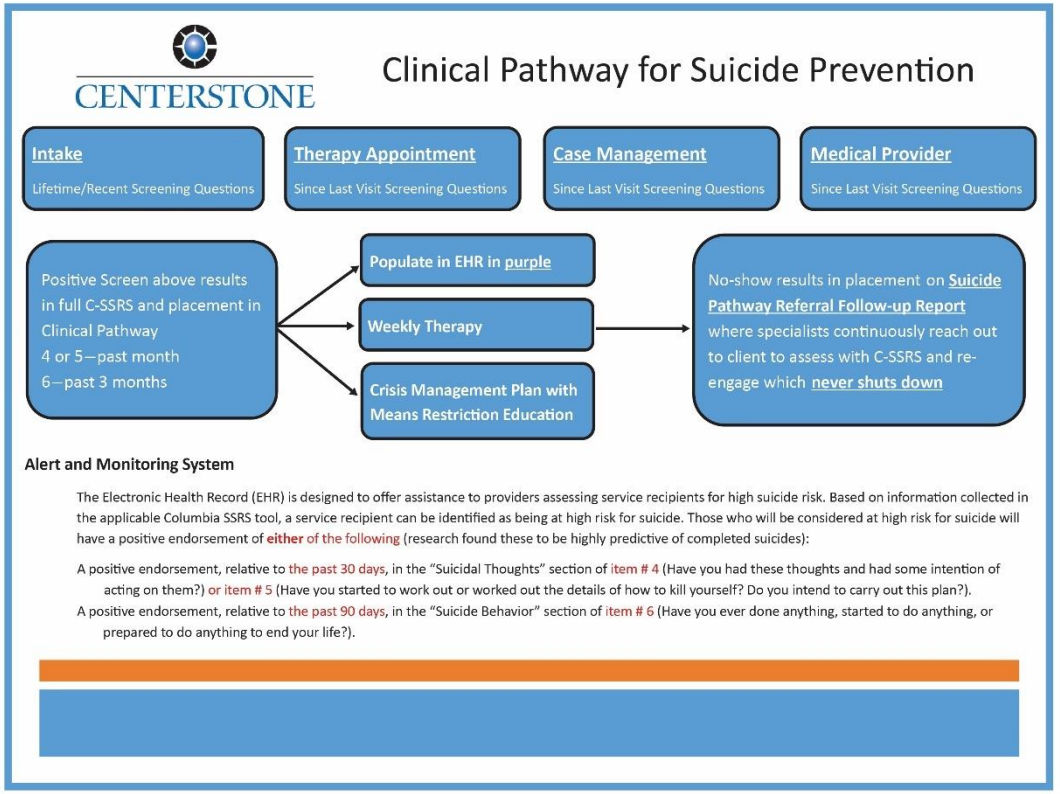
The Columbia Lighthouse Project
Identify Risk. Prevent Suicide.

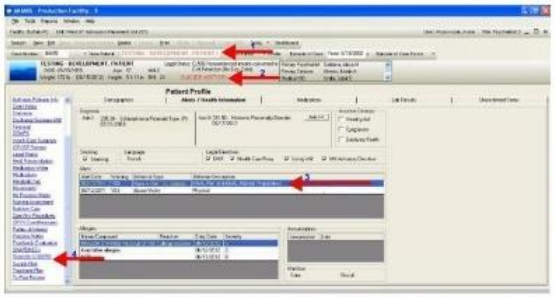
# Well Delineated Streamlined Big System Alerting Policies: Optimizing Identification of Those at High Risk Across the Continuum of Care

"With so many patients it's like mining for gold and **the Columbia is the sifter"**

**Alerting System…** suicide reduction in primary care



New York State Electronic Medical Record

*Risk Info Travels*

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IDENTIFY RISK. PREVENT SUICIDE.

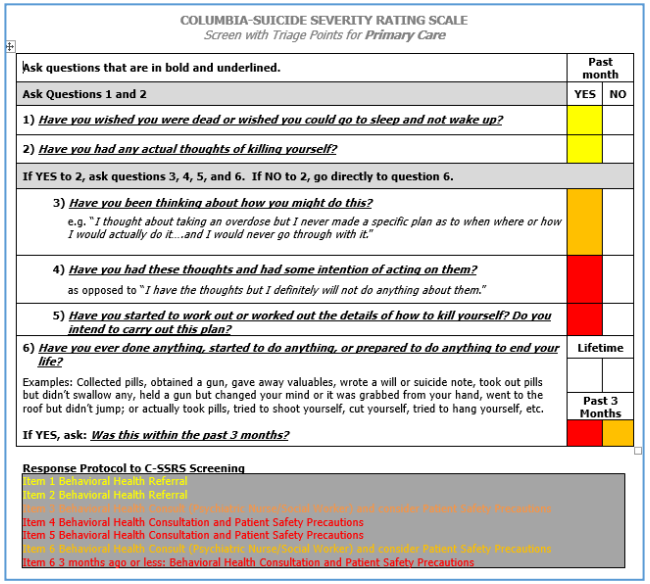
## How High Risk Data Gets Used:
## The Importance of Tracking and Alerting Across a State

# Improving Suicide Screening at the Cleveland Clinic through Electronic Self-Reports: PHQ-9 and the Columbia-Suicide Severity Rating Scale (C-SSRS)

Irene L. Katzan[1], M.D.; Adele C. Viguera[1], M.D., M.P.H; Taylor Burke[2], B.A.; Jacqueline Buchanan[2], A.B.; Kelly Posner[2], Ph.D.
[1]Cleveland Clinic [2]Columbia University Medical Center

## Screen - Triage - Identification Of High Risk

**3 in One**



COLUMBIA-SUICIDE SEVERITY RATING SCALE
*Screen with Triage Points for **Primary Care***

| Ask questions that are in bold and underlined. | Past month YES | NO |
|---|---|---|
| **Ask Questions 1 and 2** | | |
| 1) ***Have you wished you were dead or wished you could go to sleep and not wake up?*** | | |
| 2) ***Have you had any actual thoughts of killing yourself?*** | | |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.** | | |
| 3) ***Have you been thinking about how you might do this?*** e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it…and I would never go through with it.*" | | |
| 4) ***Have you had these thoughts and had some intention of acting on them?*** as opposed to "*I have the thoughts but I definitely will not do anything about them.*" | | |
| 5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** | | |
| 6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. | Lifetime | |
| **If YES, ask:** ***Was this within the past 3 months?*** | Past 3 Months | |

**Response Protocol to C-SSRS Screening**
Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Behavioral Health Consultation and Patient Safety Precautions
Item 5 Behavioral Health Consultation and Patient Safety Precautions
Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions

### As Opposed To...

**PHQ9 Single Item** → Risk Determination with C-SSRS

**Air Force Zero Suicide** at mental health clinics
at risk (intake) **16% PHQ9 vs 6.5% C-SSRS**
at risk (follow-up) **13% PHQ9 vs 1.3% C-SSRS**

**Cleveland Clinic:** Outpatient Psychiatry
6% positive on C-SSRS vs. 24% endorsed PHQ item 9

**Connecticut Children's:**
C-SSRS evaluation of ASQ positive screens determined 60% of them to be low risk
i.e. that step could have been avoided

# Optimizing Care Delivery with Universal Screening: PHA only .04% Identified as High Risk

Parkland
*Health & Hospital System*
*Dallas, Texas*

**First-Ever Universal Screening uses the C-SSRS at Parkland Memorial Hospital: only 1.8% positives of 100,000 patients**

- Policy: used in every soldier-soldier and leadership-soldier interaction.
- Periodic Health Assessment: Over **38,000** screenings completed in **PHA,** identifying **17** soldiers needing assistance (.045%).
- **No suicides** in any of those screened.

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# Barriers to Screening: Stigma, Fear and Liability

## The Data Supports the Public Health Approach, Getting the Highest Risk People to Care

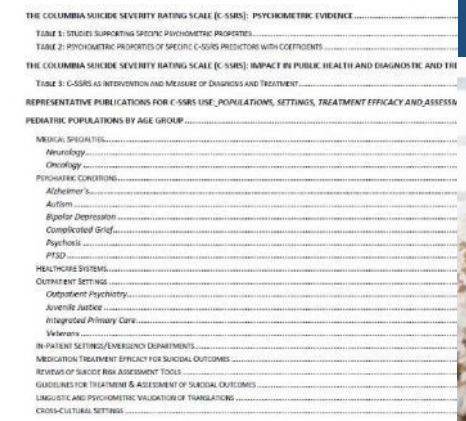
**"I'm afraid to ask because I don't know what to do with the answer."**
**"If I ask, will I put the idea in their head?"**

***Asking actually relieves distress*** **— people who are suffering want help but don't necessarily have the will to come to you** *(Gould 2005)*

The Columbia Lighthouse Project/Center for Suicide Risk Assessment

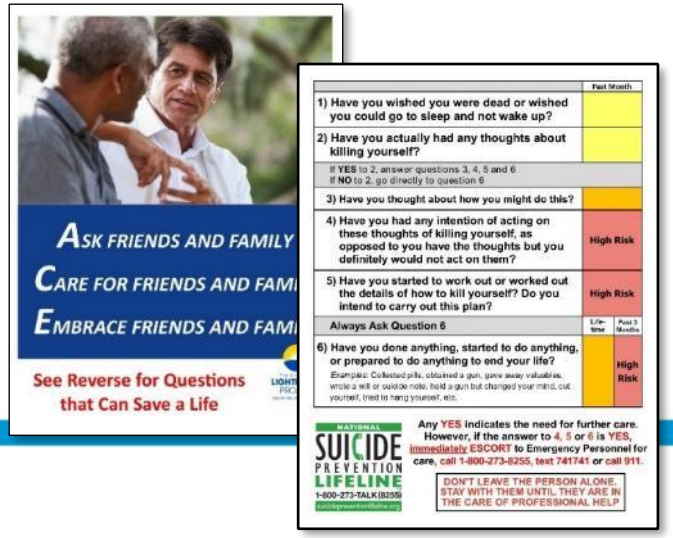
The Columbia Suicide Severity Rating Scale (C-SSRS)

Supporting Evidence



**Protects Against Liability: Internal and External**

"If a practitioner asked the questions... It would provide some legal protection"
– Mental Health Attorney, Crain's NY




- **Over 120 studies supporting across cultures, properties and sub-populations**
- **Over 1000 published studies reference it**
- **Sweden study from 2021: Proven ability to predict death by suicide**

# *Breaking Down Barriers:*
## Asking These Questions Protects Against Liability

"If a practitioner asked the questions... **It would provide some legal protection"**

–Bruce Hillowe, mental health attorney specializing in malpractice litigation (Crain's NY, 11/8/11)

Implemented by national risk managers of *The Doctor's Company*, a medical malpractice insurance company, to be used by physician members

"I believe it sets the standard…we take a proactive position in patient safety" – Patient Safety Risk Manager

"People don't get sued for something bad happening, they get sued for negligence."

52. At 3:18 a.m. Matt was triaged by a registered nurse and scored as "high risk" by the Columbia-Suicide Severity Rating Scale ("C-SSRS") screening and was immediately placed on suicide precautions. It was noted that Matt was "suicidal with a specific plan." An order was entered for an ER Counselor consult, and Matt was visually observed every fifteen minutes.

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Schools are legally required to take "reasonable measures" to keep students safe when they express intent to act on suicidal thoughts (C-SSRS Question 4 or 5) or if there has been a suicide attempt at school or soon before matriculation that they have knowledge of. (C-SSRS Question 6)


With these considerations in mind, we conclude that a university has a special relationship with a student and a corresponding duty to take reasonable measures to prevent his or her suicide in the following circumstances. Where a university has actual knowledge of a student's suicide attempt that occurred while enrolled at the university or recently before matriculation, or of a student's stated plans or intentions to commit suicide,[16] the university has a duty to take reasonable

---

[16] The Columbia Lighthouse Project, under the auspices of Columbia University, created the Columbia-Suicide Severity Rating Scale(C-SSRS), a suicide risk assessment tool that provides useful guidance. See Columbia-Suicide Severity Rating Scale. http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/ [https://perma.cc/TR7Y-S8JB]. More specifically, C-SSRS category four or five behavior is informative of what constitutes a student's stated plans or intentions to commit suicide:

> "4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan -- Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to 'I have the thoughts but I definitely will not do anything about them.'
>
> "5. Active Suicidal Ideation with Specific Plan and Intent -- Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out."

(Emphasis in original.) See Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann, Columbia-Suicide Severity Rating Scale (C-SSRS), Lifetime Recent, Version 1/14/09 m9/12/17 (2008).

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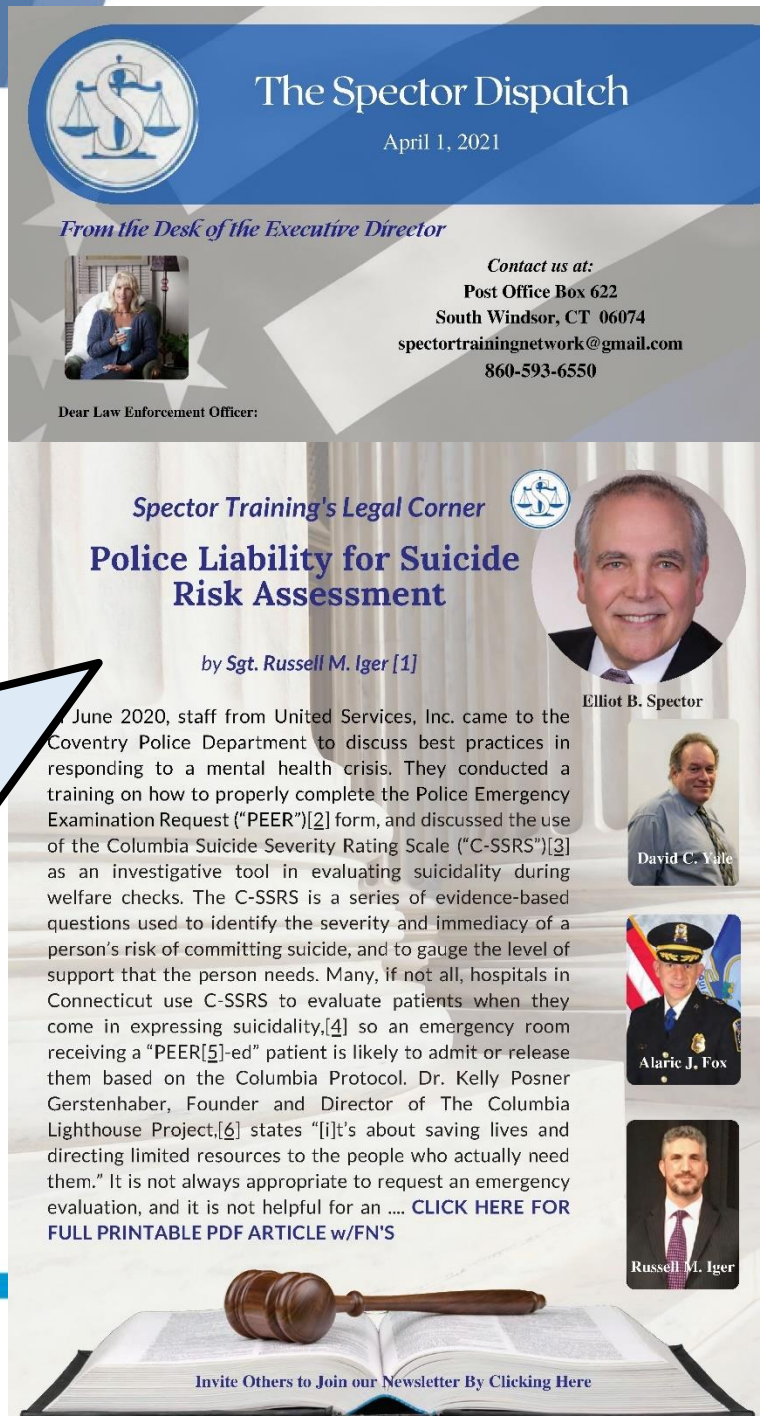
# Liability Barrier Knocked Down: Columbia is “A Game Changer”

**Previously, it was “simply an officer relying on their gut feeling and maybe transporting somebody to the ER because of liability reasons.**

Having the C-SSRS to assist the officer in determining the next steps to take when responding to a person who is having a mental health crisis can be **an indispensable tool** to help make crucial decisions ... Departments that embrace the use of the C-SSRS will have **added protection against liability** for the discretionary acts of their officers in this area. Much like the introduction of de-escalation techniques into the realm of police response, the C-SSRS acts as a tool for officers to solve the problems they encounter and **bring the proper resources to their communities that help save lives.**

**Policy for Police Officers Across Connecticut →**



The Spector Dispatch

April 1, 2021

*From the Desk of the Executive Director*

*Contact us at:*
Post Office Box 622
South Windsor, CT 06074
spectortrainingnetwork@gmail.com
860-593-6550

Dear Law Enforcement Officer:

*Spector Training's Legal Corner*

## Police Liability for Suicide Risk Assessment

*by Sgt. Russell M. Iger [1]*

Elliot B. Spector

David C. Yale

Alaric J. Fox

Russell M. Iger

June 2020, staff from United Services, Inc. came to the Coventry Police Department to discuss best practices in responding to a mental health crisis. They conducted a training on how to properly complete the Police Emergency Examination Request (“PEER”)[2] form, and discussed the use of the Columbia Suicide Severity Rating Scale (“C-SSRS”)[3] as an investigative tool in evaluating suicidality during welfare checks. The C-SSRS is a series of evidence-based questions used to identify the severity and immediacy of a person’s risk of committing suicide, and to gauge the level of support that the person needs. Many, if not all, hospitals in Connecticut use C-SSRS to evaluate patients when they come in expressing suicidality,[4] so an emergency room receiving a “PEER[5]-ed” patient is likely to admit or release them based on the Columbia Protocol. Dr. Kelly Posner Gerstenhaber, Founder and Director of The Columbia Lighthouse Project,[6] states “[i]t’s about saving lives and directing limited resources to the people who actually need them.” It is not always appropriate to request an emergency evaluation, and it is not helpful for an .... CLICK HERE FOR FULL PRINTABLE PDF ARTICLE w/FN'S

Invite Others to Join our Newsletter By Clicking Here

# Everyone, Everywhere Can Ask and Needs to Ask: Needs to be Policy

**VT Policy recommendation and role play for school janitors**

**Zero Suicide community workshop for custodians and receptionists**

**Future VA stand-down: From canteen worker to cemetery worker**

Theater Workers for At Risk Youth

**79% of Black youth who die by suicide die at home – for ages 5-11, it's 95%**


"Screening normalizes the conversation. We need to change the culture so that it becomes like taking your blood pressure – everybody gets asked."

# Must Go Beyond the Medical Model Towards a Public Health Approach:

**Marines reduced suicide by 22%** while at the same time there was a reduction in domestic violence, alcohol incidents & sexual assault


## Undersecretary of Defense Urgent Memo

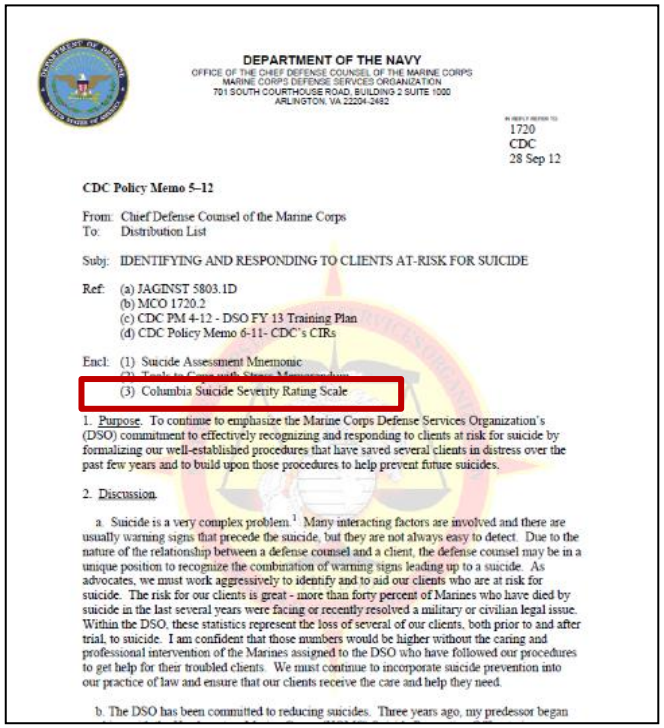
OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

MEMORANDUM FOR DEPUTY ASSISTANT SECRETARY OF THE ARMY FOR MILITARY PERSONNEL/QUALITY OF LIFE
DEPUTY ASSISTANT SECRETARY OF THE NAVY FOR MILITARY PERSONNEL POLICY
DEPUTY ASSISTANT SECRETARY OF THE AIR FORCE FOR RESERVE AFFAIRS AND AIRMEN READINESS

SUBJECT: Use of the Columbia-Suicide Severity Rating Scale

- **Total force roll-out**, in the hands of whole community
- **ALL support workers including lawyers**, financial aid counselors, chaplains, family advocacy workers, substance abuse specialists, advocates



DEPARTMENT OF THE NAVY
OFFICE OF THE CHIEF DEFENSE COUNSEL OF THE MARINE CORPS
MARINE CORPS DEFENSE SERVICES ORGANIZATION
701 SOUTH COURTHOUSE ROAD, BUILDING 2 SUITE 1000
ARLINGTON, VA 22204-2482

1720
CDC
28 Sep 12

CDC Policy Memo 5-12

From: Chief Defense Counsel of the Marine Corps
To: Distribution List

Subj: IDENTIFYING AND RESPONDING TO CLIENTS AT-RISK FOR SUICIDE

Ref: (a) JAGINST 5803.1D
(b) MCO 1720.2
(c) CDC PM 4-12 - DSO FY 13 Training Plan
(d) CDC Policy Memo 6-11- CDC's CIRs

Encl: (1) Suicide Assessment Mnemonic
(3) Columbia Suicide Severity Rating Scale

1. Purpose. To continue to emphasize the Marine Corps Defense Services Organization's (DSO) commitment to effectively recognizing and responding to clients at risk for suicide by formalizing our well-established procedures that have saved several clients in distress over the past few years and to build upon those procedures to help prevent future suicides.

2. Discussion.

a. Suicide is a very complex problem.[1] Many interacting factors are involved and there are usually warning signs that precede the suicide, but they are not always easy to detect. Due to the nature of the relationship between a defense counsel and a client, the defense counsel may be in a unique position to recognize the combination of warning signs leading up to a suicide. As advocates, we must work aggressively to identify and to aid our clients who are at risk for suicide. The risk for our clients is great - more than forty percent of Marines who have died by suicide in the last several years were facing or recently resolved a military or civilian legal issue. Within the DSO, these statistics represent the loss of several of our clients, both prior to and after trial, to suicide. I am confident that those numbers would be higher without the caring and professional intervention of the Marines assigned to the DSO who have followed our procedures to get help for their troubled clients. We must continue to incorporate suicide prevention into our practice of law and ensure that our clients receive the care and help they need.

b. The DSO has been committed to reducing suicides. Three years ago, my predessor began

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# Suicide Rate in Air Force Decreases with Everyone Asking

## **Zero Suicide:** Whole-Community Systems Approach in the Air Force

Airman, Clergy, Dentist, Spouse etc

**Support Workers**
- Clergy
- Legal Assistants
- Financial Aid Counselors
- Advocates
- Case Managers

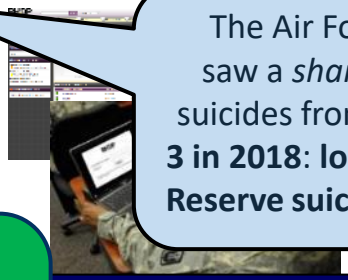

**Peers & Leadership**

**Security/Safety**
- Overnights
- Explosive Ordinance Disposal
- Military Police

**Schools, Child & Family Services**

**When A Community Comes Together There is Hope**

**Primary Care, Dentistry**



**Behavioral Health**

The Air Force Reserves saw a *sharp decrease* in suicides from **11 in 2017** to **3 in 2018**: **lowest number of Reserve suicides since 2012.**

**Spouses**

**"If I had the Columbia Scale, I never would have left him alone in that hotel that day."** - Kim Ruocco

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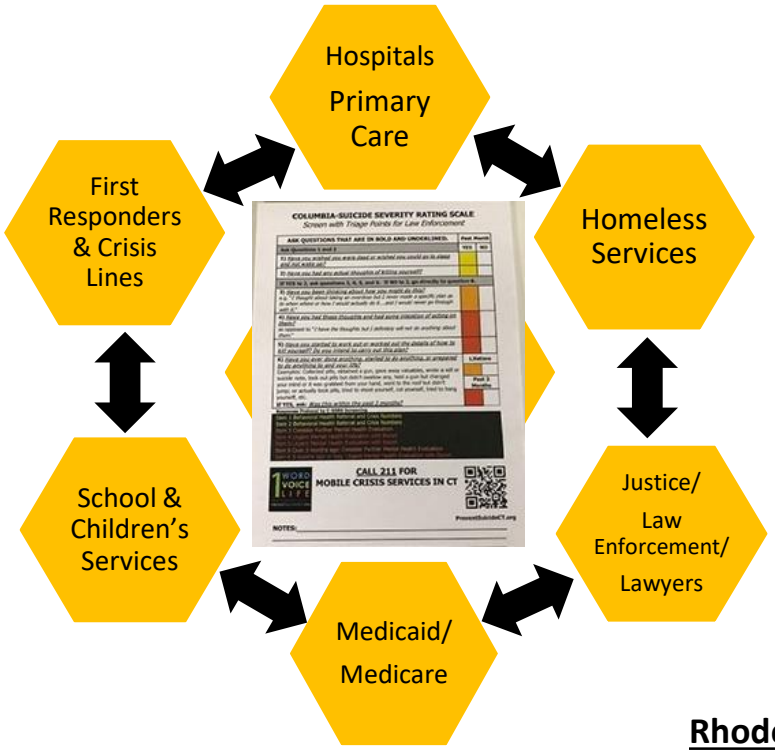
IDENTIFY RISK. PREVENT SUICIDE.

# Partnership between Medicine & Public Health: Quickening Care Delivery through Linking of Systems Across All Agencies and Systems Across State or Nation

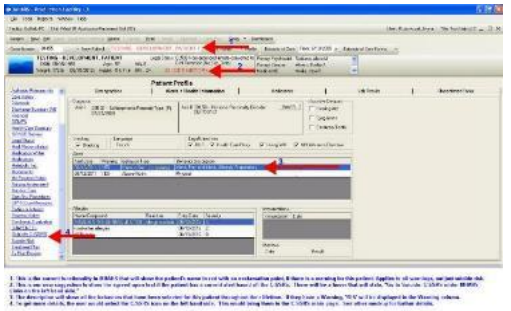
| Provider by Provider | All Services | Between Services | All Systems of Care |
|---|---|---|---|

(The statewide adoption of the C-SSRS as the crisis assessment tool) "has **catapulted a transformation of practices** in TN by insuring professionals and family members who come in contact with an individual who may have thoughts of taking their own life **receive the help they need before it is too late**"

- Melissa Sparks, Director of Crisis Services and Suicide Prevention, Tennessee Department of Mental Health and Substance Abuse Services




## High-Risk Tracking and Alerting Across a State



"Nevada has implemented The Columbia Suicide Severity Rating Scale in suicide prevention gatekeeper trainings across the state. From its

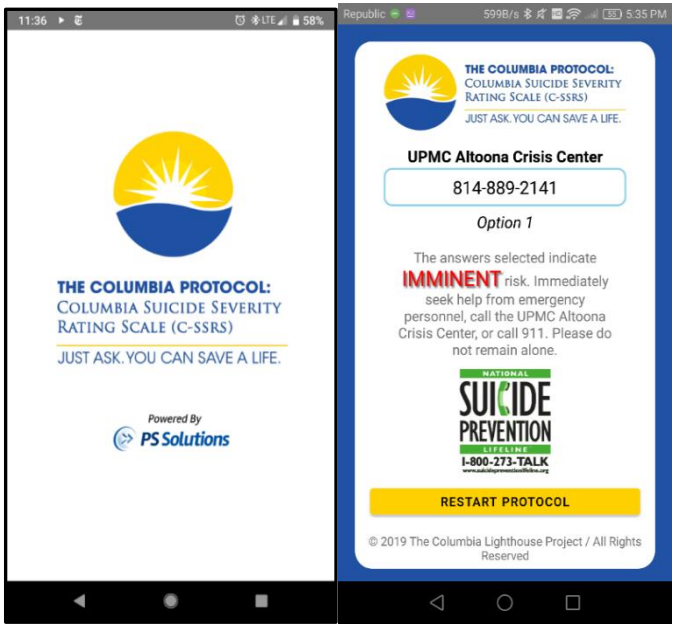
CT Alliance to Benefit Law Enforcement that do all the CITI trainings worked closely with mobile crisis providers: When Communicating with hospitals or mobile crisis upon arrival, they provide the C-SSRS findings.

A school counselor used C-SSRS to identify that a 4th grade boy was suicidal. He was sent to mobile crisis services who confirmed his C-SSRS results, then sent him to hospital who provided counseling and safety planning. **This timely intervention and continuity of care was all facilitated by each touch point using the common language of CSSRS.**

**Rhode**
**Reduced ED**


Used throughout government agencies including DHS, HHS, VA, DoD, SAMHSA, and the Office of Refugee Resettlement (HHS Administration for Children and Families)

# Finding People Where They Live with the Columbia Mobile App: With Community Crisis Information

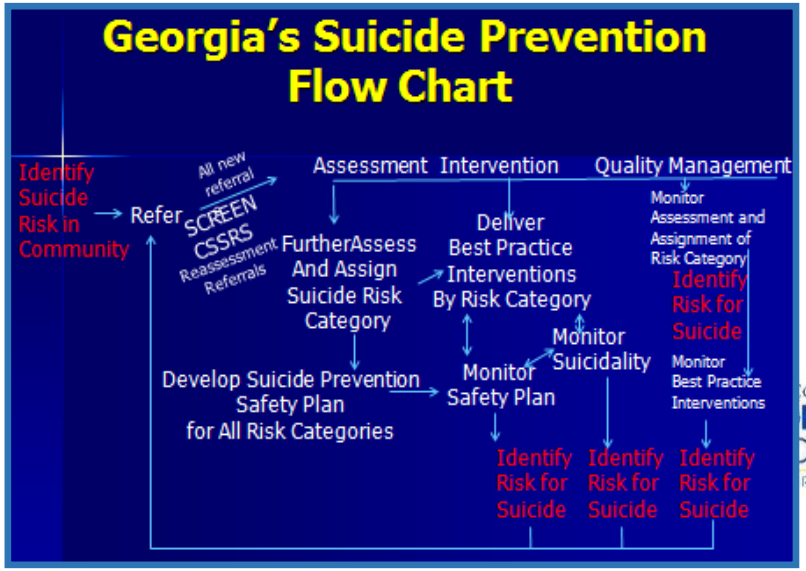




**Cerner EHR: Now over 1 million screens, using data to address barriers to health equity**

## Georgia DBHDD Implementation Plan

1. Introduced Statewide
2. Overview by region and regional support
3. Policy development at state level for **all Medicaid providers**
4. Lifeline Crisis Call Center
5. Provider by Provider implementation in all services and systems

C-SSRS Required for Medicaid Reimbursement



# Since Asking with an **"Everyone, Everywhere"** **Approach Utah Achieves Decrease in Suicide**

## Reversed an alarming increasing trend over the past 10 years

### Medicaid Improvement Plan

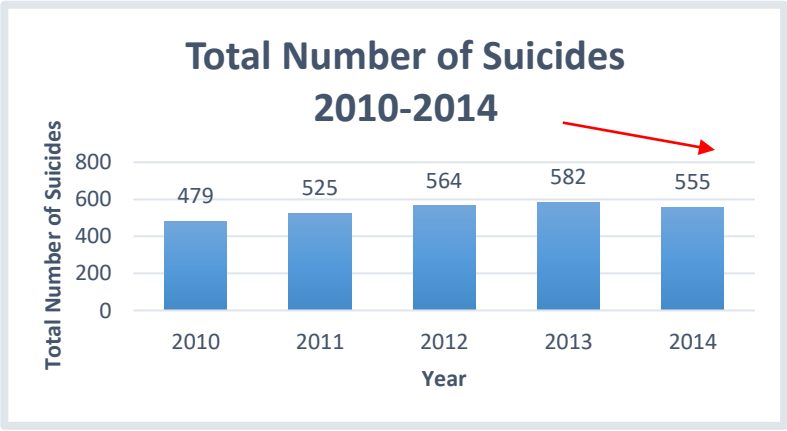
In their legislative suicide prevention report they state "we are committed to becoming a **Zero Suicide System of Care"**

"**Screening and assessment using the C-SSRS had been an important piece to this comprehensive multi system approach.** We are on year 2 of a state-wide Medicaid improvement project that **highlights the use of the C-SSRS and subsequent interventions**… Another step in our "all-in" adoption of shared tools and language"

**State Suicide Prevention Plan: Planned Legislation**

utah department of human services
SUBSTANCE ABUSE AND MENTAL HEALTH

**State Suicide Prevention Programs**
FY 2015 Report




A Nevada State Senator grappling with her state's high suicide rate looked to progress made in Utah for hope, saying, "Utah recently reversed an upward trend in suicides and experts are citing the implementation of the Columbia Suicide Severity Rating Scale."

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# Finding Veterans Where They Work, Live, and Thrive

***60% don't get care at the VA***

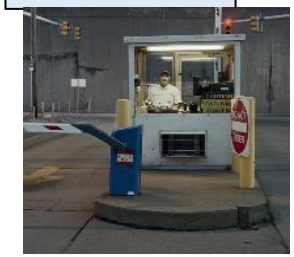
**Veterans on Campus Program**

- They can be the Ambassadors bringing awareness and resources to their peers
- Gives a **Renewed Sense of Purpose**
- Developed award-winning **Guardian** app to evaluate social media posts for warning signs and link to the Columbia Protocol

**Gyms**/Crossfit: fitness meet-ups

**Transportation Services:** Van drivers taking vets to appointments

**VA parking lot attendants**



**Reaching Veterans Everywhere in the Community**

**Lawyers & Legal assistants:** legal problems are a major precipitant

After a VA attorney used the Columbia to help save the life of a suicidal client, the OGC decided to make it scalable and put it in the hands of all attorneys and legal aids throughout the VA nationwide.

**Custodial staff**


**At the DMV:** Vets get special driver's licenses

Dept of Parks & Recreation


**Veterans Benefits Officers**

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# Whole-Community Approach in Schools and Universities:
## In Everyone's Hands

### Veterans on Campus Program
- They can be the Ambassadors
- Gives a **renewed sense of purpose**
- Bringing awareness and resources to their peers

### Teachers and Professors
- Librarians
- Teaching Assistants (TAs)

### Admin and Staff
- Principles
- Deans
- Office staff
- Custodial staff
- Food service staff

### Behavioral Health
- Guidance counsellors
- Advisors
- Behavioral health clinic staff

### Peers

**When A Community Comes Together There is Hope**

### Coaches


### Residence Hall Staff
- Resident Assistants (Ras)

### Security/Safety
- Campus Police
- Residence Hall Security
- Transportation workers

### Parents

# Global Policy Toolkit: Guidance for Every Part of a Community

Headquarters U.S. Air Force
Integrity - Service - Excellence
Chaplain Corps Suicide Assessment Training
Columbia Suicide Severity Rating Scale (C-SSRS)
USAF Clergy

Israel Schools

South Carolina Schools

New Zealand Corrections

Hospital Systems

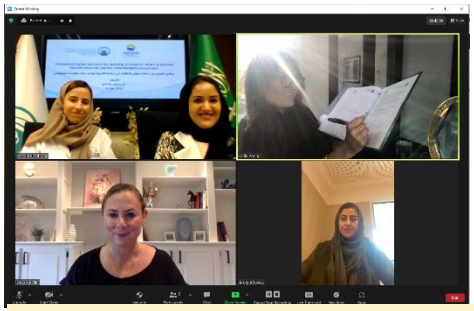
States

Military

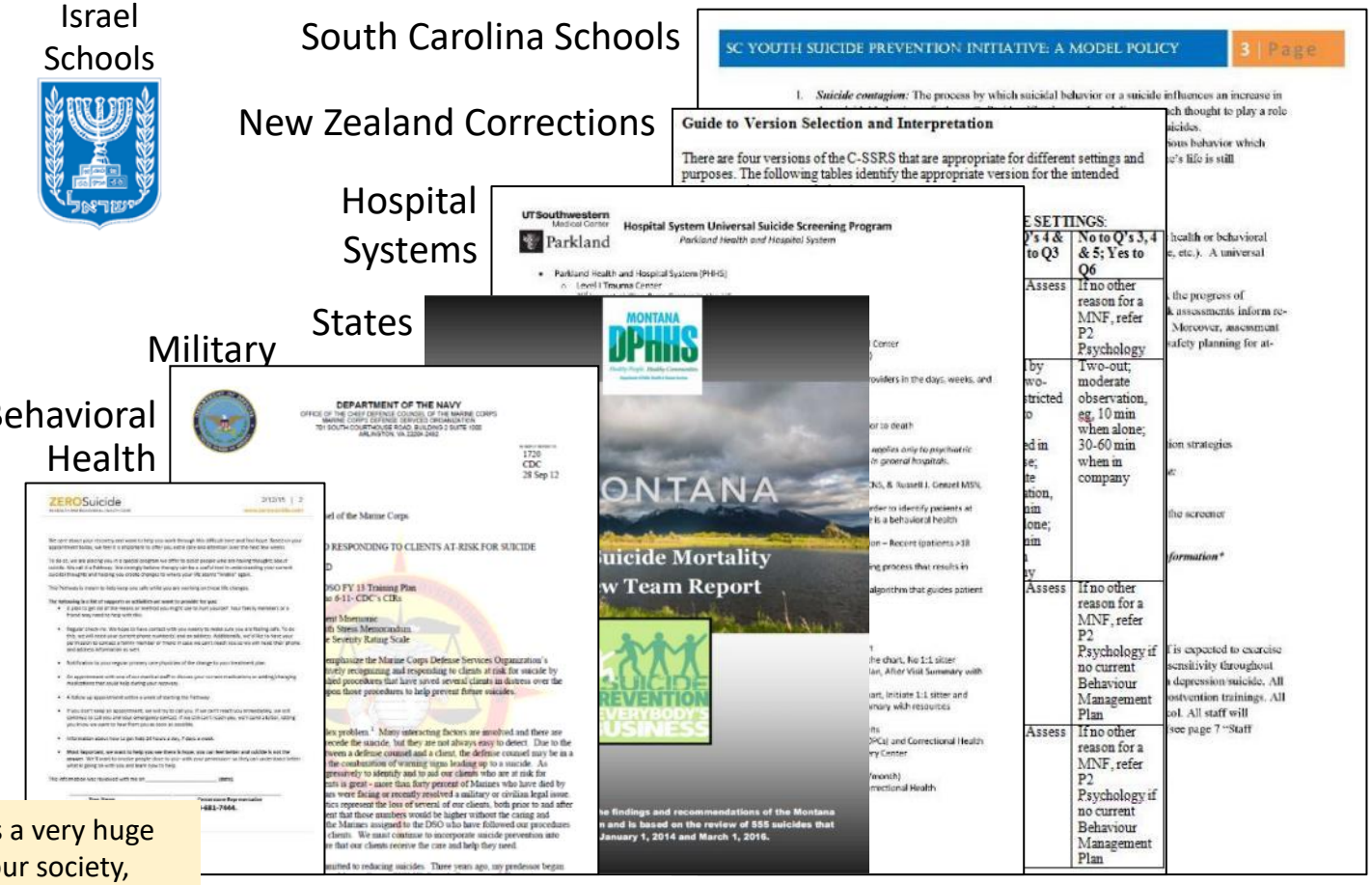
Behavioral Health

Saudi Arabia

جامعة الأميرة نورة بنت عبدالرحمن
Princess Nourah bint Abdulrahman University



"From our cultural perspective, it's a very huge step to admit what is going on in our society, mainly in our university. So we are very excited to go for the next step and to really work on this executive program between these two nations."

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# Why National Agencies, Regulatory Bodies, States and Nations Have Clarified the Critical Need for a Common Method


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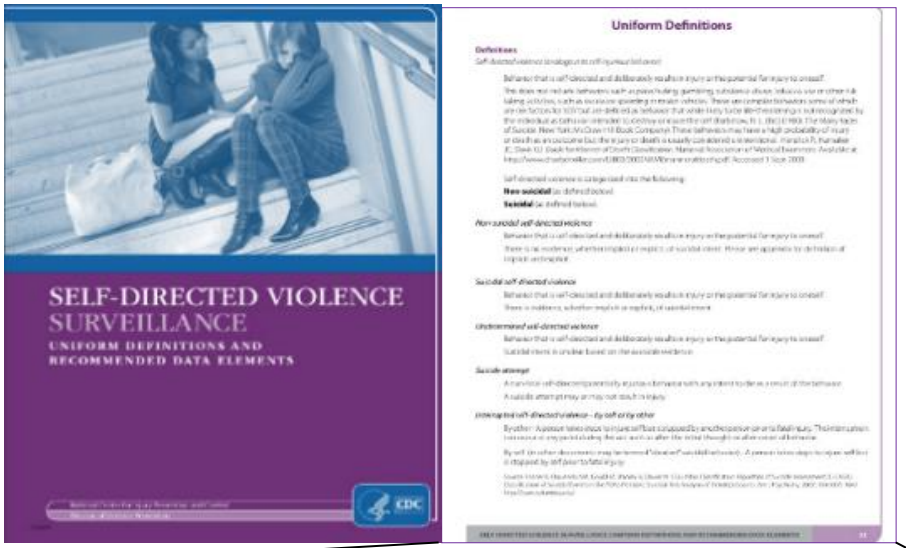
# *The Importance of a National & Global Common Language*

## Increases Knowledge and Improve Standard of Care

## Adopted by CDC: "The Need for Consistent Definitions"

**"The C-SSRS is changing the paradigm in suicide risk assessment in the US and worldwide" – Alex Crosby**

**" Research on suicide is plagued by many methodological problems… Definitions lack uniformity… reporting of suicide is inaccurate…"**
***Reducing Suicide*** **Institute of Medicine, 2002**




**Also from CDC:**
"Unacceptable Terms"
- *Completed suicide*
- Failed attempt
- Parasuicide
- *Successful suicide*
- Suicidality
- Nonfatal suicide
- Suicide gesture
- Manipulative act
- Suicide threat

Source: Posner K, Oquendo MA, Gould M, Stanley B, Davies M. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. Am J Psychiatry. 2007; 164:1035-1043. http://cssrs.columbia.edu/

SELF-DIRECTED VIOLENCE SURVEILLANCE: UNIFORM DEFINITIONS AND RECOMMENDED DATA ELEMENTS 21

"Playing from the same sheet of music"

# National and International Agencies Identify Need for Common Method in Order to Increase Knowledge and Improve Standard of Care

- Prominent Research Agendas Speak about Uniformity
- Measurement imprecision is *particularly problematic* in dealing with events with low incidence.
- **Common language ensures comparisons and pooling of** data across studies, increases the scientific impact of each study, and helps accrue knowledge.
- **National Action Alliance for Suicide Prevention (2014):** A prioritized research agenda for suicide prevention in healthcare systems
- **FDA Guidance to the Industry (2012)**
- **PhenX Project (Phenotypes and eXposures)** funded by the National Human Genome Research Institute (NHGRI) and the National Institute on Drug Abuse (NIDA) to integrate genetics and epidemiologic research.


**Guidance for Industry**
**Suicidal Ideation and Behavior: Prospective Assessment of Occurrence in Clinical Trials**


Moving away from a single instrument inherently degrades the precision of the signal, compounding imprecision when combining data.

"It should be noted that the **use of different instruments is likely to increase measurement variability…decreasing the opportunity to identify potential signals in future meta-analyses**…this type of imprecision is particularly problematic in dealing with events that have a low incidence, as is the case for suicidal ideation and behavior occurring in clinical trials." –FDA Guidance

The impact of ***imprecision grows when incidence rates are low*** : 1% vs. 3% or misclassification of 1 or 2 cases can profoundly change conclusions about drug effects.


**National Research Agenda:** Common Goal, Method and Data Elements: Inconsistency in definitions and lack of uniformity in method of detection is one of the major impediments to prevention (US National Suicide Prevention Strategy 2012, National Academy of Medicine 2002).

## From Congress to Regulatory Bodies – Medical and Beyond

# Joint Commission: *Vital Signs*

## The U.S. National Regulatory Body Says this Needs to be a Vital Sign and Every Part of an Organization Needs to Ask the Same Questions .

**Basis for JC Regulatory Policy:** "Intent to Act"

[Hospitals and health care systems] "have either developed something themselves or they're using a piecemeal approach, with different tools in different departments: What may appear to be a person at risk in one area may not appear to be at risk in another. **When the ED is asking their set of questions, and then the social worker asks another set**, then the psychiatrist asks another, you're reducing the signal strength. **You're not homing in on the needle in the haystack."**

**Joint Commission: *Vital Signs***

"By adopting the C-SSRS, organizations ensure that **one tool is being used by all caregivers** … Using **the same language helps all caregivers** understand what the patient needs" … "**focus on folks who are at highest risk.**"

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# A Common Language is an Intervention In and of Itself: Asking Can Literally Be Medicine Because it Shows You Care

**Huge Study Showed Biggest Impact in Stopping Kids From Trying to Take Their Own Lives is Peers Helping Each Other**

- "Just Ask" is much more than a screening intervention
- **Study in 10 EU countries with >11,000 students: peer-to-peer component** is most effective
- CDC: Common language develops **Connectedness –** which saves lives
- Even if you are lucky enough to see a professional it's likely only 1x/week, so **we all need to check on our friends, coworkers and neighbors** more consistently

**The Magnitude of Connecting: Devastating Health Effects of Loneliness Equivalent to 15 Cigarettes a Day**

***More Lethal than Heart Disease or Obesity***

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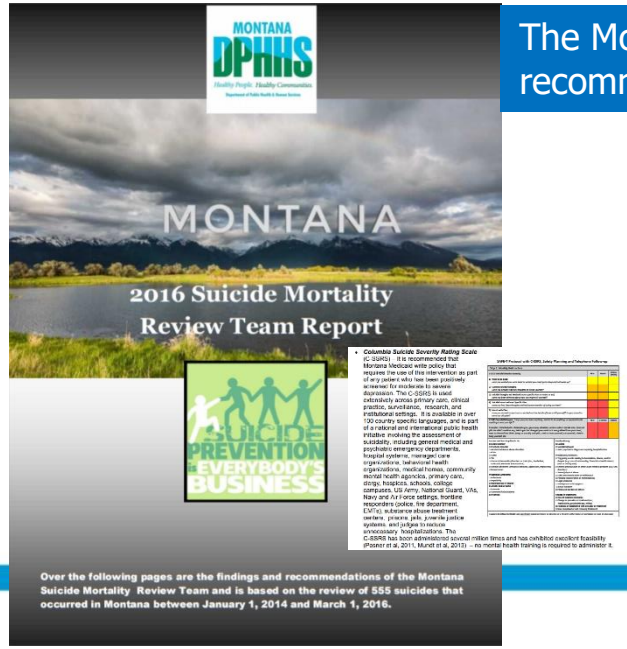
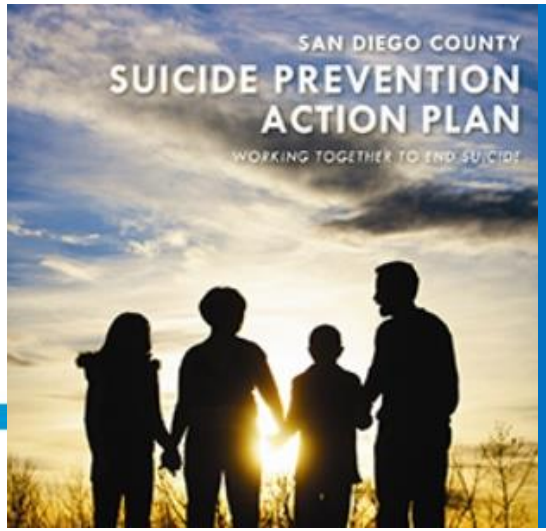
# Columbia's Large Screening Data Not Only an Intervention But Helps Prioritize Resources for Prevention Efforts

- **Data helps prioritize needs and resources** for preventing suicide
  - Screening All Coast Cadets led to resources for improved prevention training and treatment (and engagement: several Cadets coming forward to ask for help)
- Collecting data on where, when, and by whom the C-SSRS is used ***allows us to see how systems can be improved***
- Adoption of screening and tracking across all public settings – we collect data that **informs broader prevention efforts**



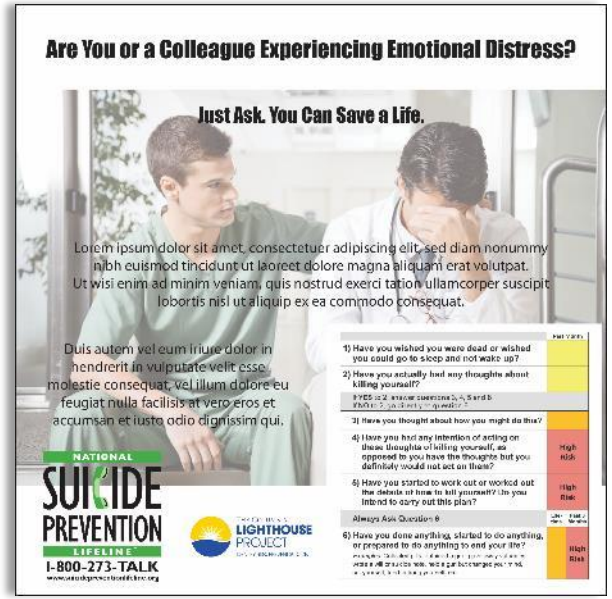

The Montana 2016 Suicide Mortality Review Team Report recommended that Medicaid policy require C-SSRS




San Diego County

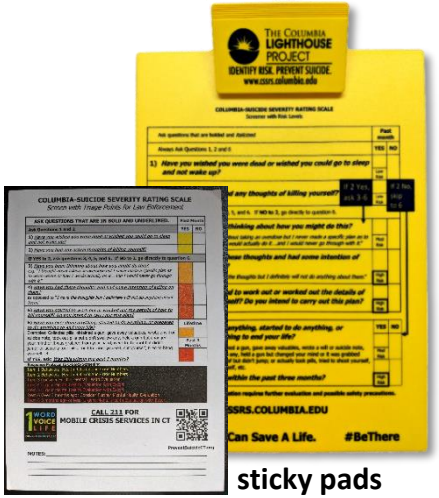
- C-SSRS included in the San Diego County Suicide Prevention Action Plan.
- A data-driven program evaluation report facilitated a 5-year grant from San Diego County Health and Human Serves Agency to implement county-wide standardized risk assessment procedures and expand crisis intervention.

# Just as Important to have Flexible and Innovative Delivery as to Have the Right Questions




**Posters in Workplaces**


**Electronic delivery, automatic risk notification**



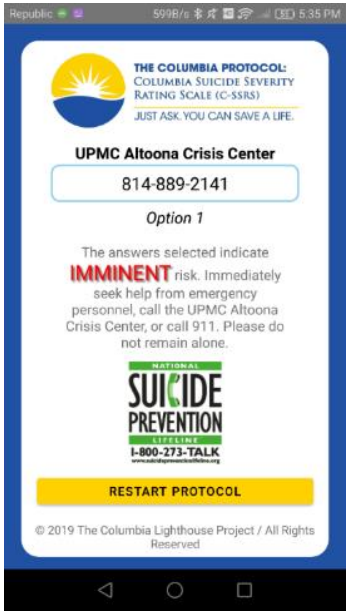

**sticky pads**


University of Tennessee Chattanooga "Badge Buddies"

**Telehealth:** Research shows it is equivalent to in-person care in diagnostic accuracy, tx effectiveness, quality of care, and patient satisfaction

## The Columbia Mobile App:

With Individualized Community Crisis Information




**Search the app store for Columbia protocol**

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# Breaking the Silence and Helping Communities Heal

At one point in history, **learning to wash hands** began saving lives. Now, just asking and **being there for each other** gives us permission to connect and build a **path of openness and resilience** that spans generations and is helping us save lives today.

**"This is not only saving millions of lives, it is literally changing the way we live our lives, breaking down barriers that have been built over thousands of years. But we are just one nation and every nation deserves this lifesaving tool."**

- Israeli official

"The beauty of the Columbia Protocol is that anyone can be involved. **So, as a community, we don't have to sit back and feel powerless. We can feel like we're part of a solution.**
**It really does help in our own personal trauma and healing**"

- Ryan Petty

*Memorial events or other positive gatherings led by students or the community are known to be particularly healing after a traumatic event*

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For questions and other inquiries,

email: *kelly.posner@nyspi.columbia.edu*

Website for more information and downloads:

**cssrs.columbia.edu**

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